STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	02/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OASIS ASSISTED LIVING, INC	4301 WASHINGTON AVE, EVANSVILLE, , 47714

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE
R 0000	INITIAL COMMENTS This visit was for a State Residential Licensure Survey. Survey dates: February 18, 2025 Facility number: 013613 Residential Census: 61 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on February 21, 2025.	R 0000	The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance. Preparation or execution of this plan of correction does not constitute provider admission or agreement related to the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The plan of Correction is prepared and executed solely because it is required by the position of State Law. The Plan of Correction is submitted in response to the annual survey on February 18, 2025. All facility training and corrections will be implemented on or before March 16, 2025.	

			Please accept this Plan of Correction as the provider's credible allegation of compliance. The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	
R 0117	Personnel - Deficiency 410 IAC 16.2-5-1.4(b) (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing	R 0117	R0117 Personnel - Deficiency **1.** **What corrective action will be accomplished for residents affected?** To ensure the correction of the deficient practice of all CPR certified staff not having the hands on component; the facility will audit all employee files to ensure a current CPR with the hands on component is in place for all required employees. All current employees whose position whose current CPR lacks the hands on component will be	03/16/2025

	services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on interview and record review, the facility failed to ensure at least one staff member was on duty at all times with a current Cardiopulmonary Resuscitation (CPR) Certification in accordance with state laws for 7 of 7 days reviewed. CPR certification did not have a hands on component. Finding includes: On 2/18/25 at 11:00 A.M., staffing was reviewed for the period of 2/11/25 through 2/18/25. At that time, CPR certification was provided for staff who worked in the facility during that period. The certifications indicated requirements had been completed though (Name of Health Care Academy).		re-certification, and will be enrolled in person CPR certification course. CPR certification will be provided on an ongoing basis to all staff to ensure a current CPR with hands on component. The Director of Nursing has enrolled in a CPR Instructor certification course through the American Red Cross to ensure the facility can offer in house CPR certifications to all staff upon hire and upon renewal. **2.** **How** **will the facility identify other residents having the potential to be affected** **by the same practice and what corrective action will be taken?** All residents have the potential to be affected by the same deficient practice systematic changes are as follows: To ensure compliance with healthcare safety standards and maintain a high level of emergency preparedness, a CPR certification course was held on	

	On 2/18/25 at 11:35 A.M., the (Name of Health Care Academy) website was accessed and indicated "Do you offer hands-on training? No, we do not offer hands-on training...". During an interview on 2/18/25 at 1:39 P.M., the Administrative Assistant indicated facility staff received CPR certification through the online course and no one had received hands on training. During an interview on 2/18/25 at 3:09 P.M., the Administrative Assistant indicated the facility did not have a specific policy for CPR certification for staff and that they followed the state regulations. Based on interview and record review, the facility failed to ensure at least one staff member was on duty at all times with a current Cardiopulmonary Resuscitation (CPR) Certification in accordance with state laws for 7 of 7 days reviewed. CPR certification did not have a hands on component. Finding includes: On 2/18/25 at 11:00 A.M., staffing was reviewed for the period of 2/11/25 through 2/18/25. At that time, CPR certification was provided for staff who worked in the facility		March 11, 2025, at 1:00 PM for current QMA/Nurses. This training session included a hands-on component to reinforce practical skills in life-saving interventions. Ongoing certification sessions will be scheduled until all staff members have successfully completed the required recertification process. The objective of this is to ensure that each scheduled shift has always at least one CPR-certified employee available, in alignment with Federal and State regulations. **3.** **What measures will be put into place to** **ensure this practice does not recur?** All employees will be required upon hire to provide proof of a current CPR certification with hands on component. Staff who cannot provide the requested CPR certification upon hire will be enrolled in a CPR certification course.	

	during that period. The certifications indicated requirements had been completed though (Name of Health Care Academy). On 2/18/25 at 11:35 A.M., the (Name of Health Care Academy) website was accessed and indicated "Do you offer hands-on training? No, we do not offer hands-on training...". During an interview on 2/18/25 at 1:39 P.M., the Administrative Assistant indicated facility staff received CPR certification through the online course and no one had received hands on training. During an interview on 2/18/25 at 3:09 P.M., the Administrative Assistant indicated the facility did not have a specific policy for CPR certification for staff and that they followed the state regulations.		**4.** **How corrective Action(s) will be** **monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** An audit of all CPR required staff will be completed weekly for 30 days and then monthly for 6 months to ensure all CPR required staff have a current certification that meets State and Federal regulations. All employees will be required upon hire to provide proof of their current CPR certification with hands on component. Staff who cannot provide the requested CPR certification upon hire will be enrolled in a CPR certification course.	
R 0407	Infection Control - Noncompliance 410 IAC 16.2-5-12(b)(1-4) (b) The facility must establish an infection control program that includes the following:	R 0407	R0407 Infection Control-Employee 1.	03/16/2025

	(1) A system that enables the facility to analyze patterns of known infectious symptoms. (2) Provides orientation and in-service education on infection prevention and control, including universal precautions. (3) Offering health information to residents, including, but not limited to, infection transmission and immunizations. (4) Reporting communicable disease to public health authorities. Based on interview and record review, the facility failed to ensure the infection control program included orientation and in-service education to assess the risks or exposures of Tuberculosis (TB) for staff members. Finding includes: During an interview on 2/18/25 at 3:33 P.M., the Administrator indicated the facility did not have a written policy within their infection control program related to tuberculosis screening, testing, or education for staff members, and the facility's policy was to follow state guidelines.		What corrective action will be accomplished for residents affected? For all residents affected by the deficient practice an audit was completed ensure the infection control program included orientation and in-service education to assess the risks or exposures of Tuberculosis (TB) for staff members. 2. How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken? All residents have the potential to be affected by the same deficient practice systematic changes are as follows:	

	During an interview on 2/16/25 at 3:46 P.M., the Director of Nursing (DON) indicated no staff education for Tuberculosis signs and symptoms, or ways to assess for risk factors, were provided to staff in 2024 or 2025. Based on interview and record review, the facility failed to ensure the infection control program included orientation and in-service education to assess the risks or exposures of Tuberculosis (TB) for staff members. Finding includes: During an interview on 2/18/25 at 3:33 P.M., the Administrator indicated the facility did not have a written policy within their infection control program related to tuberculosis screening, testing, or education for staff members, and the facility's policy was to follow state guidelines. During an interview on 2/16/25 at 3:46 P.M., the Director of Nursing (DON) indicated no staff education for Tuberculosis signs and symptoms, or ways to assess for risk factors, were provided to staff in 2024 or 2025.		For all residents affected by the deficient practice an audit was completed ensure the infection control program included orientation and in-service education to assess the risks or exposures of Tuberculosis (TB) for staff members. All staff will be provided education upon hire and annually to assess the risks or exposures of Tuberculosis (TB) for staff members. All current staff will be provided with to education to assess the risks or exposures of Tuberculosis (TB) for staff members on or before March 16, 2025. 3. What measures will be put into place to ensure this practice does not recur? At the time of employment, or within one (1) month prior to employment,	

			and at least annually thereafter, employees and non-paid personnel of the facility shall be screened for tuberculosis. The first tuberculin skin test must be read prior to the employee starting work. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employee the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis. An employee	

			that has had a previously documented skin test will not be required to have another skin test but must provide documentation of a chest x-ray and annual assessments to rule out any signs or symptoms of tuberculosis. 4. How corrective Action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? An audit of all employee hire and annual TB screening will be completed weekly for 30 days and then monthly for 6 months to ensure all staff have a current TB screening that meets State and Federal regulations.	
R 0412	Infection Control - Noncompliance 410 IAC 16.2-5-12(i)	R 0412	R0412 Infection	03/16/2025

	(i) Persons with a documented history of a positive tuberculin skin test, adequate treatment for disease, or preventive therapy for infection shall be exempt from further skin testing. In lieu of a tuberculin skin test, these persons should have an annual risk assessment for the development of symptoms suggestive of tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss. If symptoms are present, the individual shall be evaluated immediately with a chest x-ray. Based on interview and record review, the facility failed to ensure an annual Tuberculosis (TB) screening was completed for 2 of 7 resident records reviewed. Finding includes: 1. On 2/18/25 at 11:08 A.M., Resident 7's clinical record was reviewed. Diagnoses included, but were not limited to, dementia. The resident was admitted to the facility on 6/23/23. The clinical record lacked a Tuberculosis (TB) test or risk assessment during the past year. 2. On 2/18/25 at 9:49 A.M., Resident 1's clinical record was reviewed. Diagnoses included, but were not limited to, dementia. The resident was		Control-Residents 1. What corrective action will be accomplished for residents affected? For all residents affected by the deficient practice an audit was completed ensure all current residents received an annual TB screening was completed. 2. How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken? All residents have the potential to be affected by the same deficient practice systematic changes are as follows: For all residents affected by the deficient practice an audit was completed to ensure the infection control program included annual TB skin testing. In lieu of a tuberculin skin test, these persons should	

admitted to the facility on 2/26/19.

The clinical record lacked a Tuberculosis (TB) test or risk assessment completed since 3/24/23.

On 2/18/25 at 2:40 P.M., the Director of Nursing (DON) indicated Resident 1 and Resident 7 did not have TB tests or risk assessments completed in 2024.

Based on interview and record review, the facility failed to ensure an annual Tuberculosis (TB) screening was completed for 2 of 7 resident records reviewed.

Finding includes:

1. On 2/18/25 at 11:08 A.M., Resident 7's clinical record was reviewed. Diagnoses included, but were not limited to, dementia. The resident was admitted to the facility on 6/23/23.

The clinical record lacked a Tuberculosis (TB) test or risk assessment during the past year.

have an annual risk assessment for the development of symptoms suggestive of tuberculosis,
including, but not limited to, cough, fever, night sweats, and weight loss. If
symptoms are present, the individual shall be evaluated immediately with a
chest x-ray.

3.
What measures will be put into place to ensure
this practice does not recur?

A tuberculin skin test shall be completed
within three (3) months prior to admission or upon admission and read at
forty-eight (48) to seventy-two (72) hours. The results shall be read in
millimeters of induration with the date given, date read and by whom

administered and read.

For residents who have not had a documented
negative tuberculin skin test result during the preceding twelve (12) months,
the baseline tuberculin skin test

	2. On 2/18/25 at 9:49 A.M., Resident 1's clinical record was reviewed. Diagnoses included, but were not limited to, dementia. The resident was admitted to the facility on 2/26/19. The clinical record lacked a Tuberculosis (TB) test or risk assessment completed since 3/24/23. On 2/18/25 at 2:40 P.M., the Director of Nursing (DON) indicated Resident 1 and Resident 7 did not have TB tests or risk assessments completed in 2024. Based on interview and record review, the facility failed to ensure an annual Tuberculosis (TB) screening was completed for 2 of 7 resident records reviewed. Finding includes: 1. On 2/18/25 at 11:08 A.M., Resident 7's clinical record was reviewed. Diagnoses included, but were not limited to, dementia. The resident was admitted to the facility on 6/23/23. The clinical record lacked a Tuberculosis (TB) test or risk assessment during the past year. 2. On 2/18/25 at 9:49 A.M., Resident 1's clinical record was		testing should employ the two-step method. If the first step is negative, a second test should be performed within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis. All residents who have a positive reaction to the tuberculin skin test shall be required to have a chest x-ray and other physical and laboratory examinations as determined by a licensed physician to complete a diagnosis 4. How corrective Action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? An audit of all new admissions and annual TB screening will be completed weekly for 30 days and then monthly for 6 months to ensure all residents have a current TB screening that meets State and Federal regulations.	

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	dementia. The resident was admitted to the facility on 2/26/19. The clinical record lacked a Tuberculosis (TB) test or risk assessment completed since 3/24/23. On 2/18/25 at 2:40 P.M., the Director of Nursing (DON) indicated Resident 1 and Resident 7 did not have TB tests or risk assessments completed in 2024.			

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE